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Abstract

In a rural Indian population beset with inadequate health access to people owing to socio-cultural and economic factors, CARE India under the Maternal and Infant Survival Project encouraged village women to form Community Based Oragnisations (CBOs) and collectively save funds for health.

15 months of implementation showed that CBOs were formed in 345 of 447 project villages and health funds were operational in 203. 292 persons benefited from health funds through loans for treatment. 56% loans being repaid within the grace/low interest period.

The experience shows that village women when appropriately encouraged are capable of evolving rules and managing health funds. The process empowers village women (through access to resources and information and the strength of social capital) to take decisions and act to improve their well being.

Health funds have been have proved to be useful in addressing obstetric complications, infant illnesses and have also led to additional initiatives (social marketing of disposable delivery kits, village drug bank and plugging gaps in government supplies), that improve health care.

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INTRODUCTION AND BACKGROUND

In the past few decades the responsibility of national governments for ensuring appropriate, effective, and comprehensive health care has been reiterated. The Alma Ata Declaration of 1978 proclaiming 'health for all by the year 2000', is but one example of consensus that health is a fundamental human right. In light of budget constraints, however, the challenge has centered on how to most cost-effectively allocate resources so as to achieve national and international health goals. In the context of the developing world, where population pressure is great and budget constraints even greater, this challenge is intensified.

In attempt to honour its commitment to universal health care, India has entered, since independence, successive 5-year health plans, nation-wide health campaigns, and 'integrated' development schemes. According to the *Report of the Independent Commission on Health in India*, "the poor continue to be deprived of access to the most basic health care" (Mukhopadhyay 1997: 274). This reality is, in turn, reflected in India's health-related indicators. An Infant Mortality Rate of 68), child mortality rate of 94.9 per 1000 live births and Maternal Mortality Ratio of 540 (National Family Health Survey (NFHS), 1998-99) reflect the state of health. Prevalence rates of major morbidity in different states of the country range from 71 to 209 per 1000 persons (Shariff 1995: 41).

The state of Madhya Pradesh, a Hindi speaking state in Central India and largest in terms of land mass, scores poorly (one of "three worst states") according to indices of *Crude Death Rate, Infant Mortality Rate* and *Maternal Mortality Rate* (Mukhopadhyay 1997:8). Its vast rural population, geographical spread, infrastructure and transportation deficiencies, inefficiencies of the health delivery system, poverty and social factors render the task of health care servicing (from the providers point of view) and accessing (from the consumer's point of view) extremely difficult.

In this context, we need to move away from understanding health care financing as solely a government endeavor. Total government spending is about US$ 2-3 per capita for health services and is inadequate to meet the objectives (World Bank, 1997). As put by India's Voluntary Health Association, " there is something fundamentally wrong in the way we have been approaching health care" (Mukhopadhyay 1997: 274). CARE India' s experiences

point to one possible strategy: communities need to be made part of the picture, to be empowered and responsible agents and partners in ensuring their own health and well being.

The following paper examines community-based health financing as a strategy tried in CARE India's Maternal and Infant Survival Project to empower communities to take decisions and actions so as to improve their health and well being and thus help achieve community and government goals of increased access to health care services and facilities.

Community-Based Financing - 'An Alternative'

> "Household health care expenditure imposes a heavier burden on the poor - for them it has emerged as the largest source of indebtedness - than on the well to do. Moreover, the proportion of health care costs in the total household budget has increased several-fold during the last two decades, and it is not atypical for a poor rural household to spend Rs. 1,000 (US$ 22) or more, in the course of a year, on health and health-related needs. In fact, a single health-related illness with a day's hospitalization in a government hospital eats up 3 to 6 months of household earnings (World Bank 1997)."

Financing health care in rural India does not merely begin at the facility-level, as typically understood, but rather at the family-level involving travel costs, waiting time, food costs, medicines and loss of workdays. This phenomenon is reflected in India's National Council for Applied Economic Research figures which indicate that in spite of heavily subsidized health services, out-of-pocket expenditure on health in India is high (NCAER, 1994). Under these circumstances, where 1) people are willing to pay for certain portions of health care when required; 2) unplanned health care expenditures lead to financial instability in poor households and 3) the total cost of accessing

health care is often far in excess of the value of the actual health services received, the system requires reexamination. According to a study conducted by CARE-India on *Community Managed Health Financing*, "the rationalization of health care costs and sustainability of the system require a shift in approach - from a provider-controlled system to a client-controlled one - where people fill the gap in required resources to provide maximum quality services at a minimum cost. The effective involvement of community is an essential ingredient in this process" (CARE-India 1999).

Community health financing schemes can take on a variety of forms including grain and drug banks and community lending/borrowing groups. Their character and structure will, depend on the ideas and interests of those involved, evolving and changing with group dynamics and interests.

Institutionalized community financing, wherein resources are generated, managed and utilized *by* the community and *for* the community can ensure greater effectiveness of the system and lessen the potentially devastating effects of unplanned health expenditure on the household. Community health financing groups render the community more aware of available facilities and services, increase the demand for these, and apply pressure (even if implicit) on government structures. Government accountability improves with an informed and organized citizenship -- these Community Based Organizations (CBOs) represent one example of such citizenship.

The value of community health financing mechanisms, apart from offering a buffer arrangement for people to access loans during illness, also exert positive effects as grassroots institutions. These institutions are able to promote a sense of collective responsibility, group cohesion and initiative among the people. Increased knowledge, improved links with service providers and local agencies encourage the CBOs to aspire to work towards improved quality of life.

THE MATERNAL AND INFANT SURVIVAL PROJECT (MISP)

CARE India began the Maternal and Infant Survival Project (MISP), in January 1999 to bring sustainable and qualitative improvement in the health and nutritional status of pregnant and lactating women and infants. This project is funded by the Food Aid Center of CIDA and works in approximately 500 villages in Madhya Pradesh. The project works in close collaboration with Government counterparts (from both Ministry of Health and Family Welfare and Ministry of Women and Child Development). MISP aims to empower the community to be, not only aware of health issues, but able to make collective decisions to improve their health within the less-than -perfect supply and service scenario.

The approach

As a part of the strategy the project staff encourage village-level community based organizations (CBOs) to begin a health fund, run and administered by elected community members. The health fund takes on a number of different forms depending on community dynamics and interests. Lending/borrowing regulations and interest rates are decided upon by the group and money is held by either an elected group member or by a local bank. These health funds, in CARE's experience, have enabled the community to fill gaps in government supplies, also made it possible for families to overcome the financial barriers to accessing medical services, (transportation costs, loss of work days, cost of medicines). Moreover, and perhaps more interestingly, the community health fund has lead these groups into a number of different initiatives aimed at improving health and nutrition in the community.

Before getting into further details about particular experiences in this project with reference to these health fund groups, it is perhaps fitting to include a description of the process of formation of these groups, a process which has involved Government functionaries, CARE staff and strong community leaders. The community health fund in MISP evolved out of the Community Based Organization (CBO) structure. The CBO is a village-based group formed of active and interested community members, primarily women who have, come to appreciate the need for collective organized effort in achieving community goals (the MISP focus being on maternal and infant health-related goals). Some of these groups already existed in various forms, prior to project implementation. Through a process of discussion and brainstorming, about the various obstacles to accessing health care services, some groups

decided to begin saving for health needs. As they become more comfortable with the idea, they begin to strengthen the health fund by electing a secretary, deciding upon rules, maintaining accounts and documenting their activities.

COMMUNITY HEALTH FINANCING IN MISP

The MISP targets 447 villages. The implementation was undertaken in a phased manner. In the first phase, 104 villages were included, where project implementation started in January 1999. As of April 2000, there were a total of 345 CBOs and 203 had health funds with savings amounting to Rs. 500-2000 and membership of 10-20 people. Over 1500 people contribute to the health fund on a regular basis in the 104 first phase villages. Although many are new, approximately half of the health fund groups have begun lending out money. (Please refer to table 1 for health fund data).

Apart from savings and loans, several of these health fund groups are doing social/behavioral change marketing of safe delivery kits (SDK) and Oral Rehydration Salts (ORS). The SDK consists of a small piece of soap, a new blade, clean thread and clean cotton -- items, which contribute to the prevention of neonatal and maternal infections. Oral Rehydration Salts are mixes of glucose, potassium and sodium salts, which are dissolved in safe drinking water and given to infants and children during episodes of diarrhea to prevent dehydration.

Approximately 100 CBOs have been involved marketing of SDK and ORS. CARE supplies the CBO with a certain number of free delivery kits and ORS, which are marketed and sold to the community at a nominal fee. Those CBOs, which have been active in marketing, have had significant success, requesting a renewal of supplies. Social marketing has also helped to establish a stronger CBO presence in the village, (i.e. more community members become aware of the health fund and the benefits it brings to the village at large). The profits generated add to the health fund and have also been used to purchase unavailable supplies such as Tetanus Toxoid injection.

Table 1 gives information on the progress of health funds in the five regions where the project operates. As can be seen from the table, over half (58%) of the CBOs in the project area have a health fund. In the 104 first phase villages, a total of 292 loans were disbursed for health needs. The trend is encouraging and signifies the capacity of the rural women to manage such community savings adequately.

Table 1 - MISP Community Health Fund figures by region.
(Based on data generated by the project monitoring system)

	Hoshangabad	Pipariya	Sohagpur	Timarni	Seoni Malwa	Total/ Average
Number of CBOs with a health fund as a proportion of total number of CBOs, Apr. 00	38/75	59/74	45/69	21/49	40/78	**58.8%** 203/ 345
Number of people contributing to the health fund in Phase I villages	132	205	258	279	150	**1,030** (in 104 AWCs)
Average amount of money saved per Health Funds in Phase I villages	Rs. 987	Rs. 1,145	Rs. 1,841	Rs. 1,249	Rs. 1,012	**Rs. 1,247**
Number of loans disbursed for health reasons in Phase I villages	70/78	88/88	38/42	68/69	28/28	**292/305**
Number of health loans disbursed for purposes *other* than health in phase I villages	8/78	0/88	4/42	1/69	0/28	**13/305**
Average number of loans repaid within the grace/low interest period	32/78	79/88	14/42	30/69	17/28	**172/305**

Community Health Fund Rules

After deciding to initiate a health fund, the group sits and decides upon a set of rules (with the help of the field extension worker). Some of the rules, which the health funds use, are:

a) Eligibility criteria – Most health fund groups began with a rule of restricting the use of the health fund only to members. Some groups, however, did decide in the first place to advance loans to non-members at a higher interest rate. In those groups which had decided not to give loans to non-members, the instance of a non-member approaching the group for money for a health purpose and really being needy, has often prompted them to modify the eligibility rule so as to serve the health needs of non-members too.

b) Purpose for which loan could be advanced – Most health fund groups set the rule that the fund would be used only for health needs, but could be given out as loan for other important requirements, if approved by the health fund members. Groups, whose savings have grown substantially, have now begun to advance loans for non-health needs such as marriage and even commercial purposes.

c) Rates of interest – The health fund groups have fixed interest rates varying from 2 to 5% per month in most cases. They also have a lower interest for members than for non-members. In many cases, the group gives the borrower a grace period of 1 to 2 months, after which the loan incurs interest. This is primarily to encourage borrowers to repay timely.

d) Minimum saving by group to disburse loan – All CBOs decide on a minimum amount that they need to save (Rs 5000/- to Rs 1000/-) before they could advance the first loan.

USES OF HEALTH FUND

The following information is compiled from qualitative reports from field staff collected during their direct interaction with the community in project villages.

1. Addressing Obstetric Emergencies

Perhaps one of the most remarkable uses of the health fund has been the way in which it has enabled community members to access health care facilities when they would otherwise either not have the funds to do so, or borrowing from village money lenders at high interest rates would strongly discourage them doing so. Though such cases have been many, the following is one example of where the health fund served to render timely care available in the case of an emergency. This case is a particularly interesting because the health fund "rules" were broken in order to extend the benefits of the health fund to a poor village woman who was not a CBO member.

In one village called Chanderi, there was a woman who was experiencing prolonged labor in the late hours of the night. The family members knew that they had to get her to a hospital but had no money and were at a loss as to how to get her there. One family member then remembered the community health fund and approached one of its members, requesting a loan to take the woman to hospital. The health fund member, while understanding the urgency of the situation, was aware of the rule that states that only members were entitled to loans. She then consulted another health fund member for advice. The two members then decided that under these circumstances the rules could and should be broken. They lent out Rs.200 to the pregnant woman, helped the family identify a means of transportation to the hospital, which turned out to be a bullock cart (cart lead by bulls), and accompanied her to hospital. When the two Health fund members joined the next meeting they explained what had happened and the other members agreed that they had indeed made the right decision. The health fund rules were then altered to

add a clause for such situations. The woman successfully delivered a healthy baby. She also repaid her loan and is an active member of Chanderi's community health fund today.

2. Addressing infant illness:

Infant illnesses are also addressed by these community health funds. In the village of Pokharni, home of the *Pragati Mahila Swathya Samooh*, the village CBO having a Rs.4000-strong health fund, identified an infant suffering from 4th grade malnutrition at the Monthly Health Day. The mother of the infant was then counseled to bring the child to the hospital, a suggestion entailing borrowing Rs. 100 from the health fund. The money was borrowed and the mother brought her child to the hospital. The CBO members then visited regularly, offering counseling on feeding practices to the mother. Within three months the child was brought up to 2nd grade malnutrition and today weighs within the normal range for his age group. This case indicates a lot more than simply how money made available can help to improve access to health services. It indicates that the CBO actually also helps in nurturing a collective sense of responsibility for the health and well being of all community members.

3. Health care financing - a mechanism for gender equity and empowerment

An important element to be considered in such a discussion on health care financing is that, as most other prevalent issues in Indian, the problem of access to health care is closely related to gender. If access to health care facilities is difficult for the average village man, then it is most likely several times more difficult for the average village woman. Income, social status and culture together form a barrier disallowing women from independently taking the decision to access medical services. Moreover, the perceived inferior 'worth' of the girl child paired with the economic burden which she represent for her family, might prevent her (as opposed to her brothers) from receiving adequate care when it is needed. A resent article in the Times of India published the findings of a study conducted in Delhi among middle-class Indians which indicated that girl-children were less likely to be hospitalized for illnesses than boy-children (Times of India, January 2000). Operations and other such costly procedures were significantly less prevalent among girls than boys (Ibid.). Likewise, "numerous studies have shown the generally lower level of nutritional status among female infants than male children. Similarly, females have far less access to health services than males" (The Indian Economy 1998-99).

Therefore, the idea of a women-managed community heath fund serves to bridge the gender gap in health care accessing.

Women's Empowerment

> "Women involved in CARE's health financing initiatives have developed a sense of pride in the fact that they have been able to save a significant amount of funds in a brief amount of time (funds, they insist, which would have been squandered on trivial purchases if not saved). They express peace of mind knowing that there are funds available if they fall ill, thus the seeds of empowerment have clearly been planted. This empowerment of community groups and their members has already resulted in increased utilization of health services. Additionally, in groups where resources have been accessed; borrowing from moneylenders has declined substantially at both he group and community levels" (CARE India- 1999)

Women members of the community health fund become less dependent on their husbands or other family members, for providing money in the case of illness. Husbands of those women involved in the health fund have tended to be supportive, considering the health fund to be a way of decreasing their burden in the case of their wife/child becoming ill. The existence of the CHF has also strengthened that of the CBO as a village-level developmental body. The health fund has attracted new membership to the CBO, and has helped to create the cohesion and cooperation required to endeavor into a plethora of initiatives among which is: nutritional gardening, drug banks, and communal responsibility for the health of CHF members. Empowerment has also been born out of increased knowledge of both health-related initiatives and of resources available to the people (increased linkages). Also -- "success inspires". The more the community health fund members save, and individuals begin to borrow and repay their loans, having been helped in the process, the stronger the group becomes and the more "empowered" they feel to take on new initiative.

Other benefits of CBO and health financing

The establishment of a community health fund presupposes that health is a priority for those involved as it requires both time and money, two resources known to be scarce in the village context. The community health fund has, in CARE's experience, been more than a savings and lending program. The MISP model starts with a group, coming together to discuss health-related issues (and whatever other problems might come up). With the help of CARE staff and partners the women gain access to health information and become aware of each other's difficulties and therefore form a kind of social capital. These groups consider for health promotion activities and often conjure up ways of spreading messages to the community at large.

Greater demand of services

With the combination of increased awareness and finances available to access government services, demand increases. This demand leads to greater use of government services and greater pressure, on government, to render them appropriate and accessible. Greater awareness, paired with knowledge, has lead people to take greater care of their health, i.e. to become *actively* involved in the pursuit of good health, rather than remaining the passive recipients of government 'health-promoting' hand-outs. "…There is an emerging consensus that private acquisition of health services maximizes the welfare of the individual" (Mukhopadhyay 1997:282). It enables people not only to choose the services to use, but to appreciate the need for such services.

Nutritional gardening

In the village of Jhilpipariya, the women in the community health fund (or CBO) after recurring talks on health and nutrition-related topics, decided to begin a communal nutritional garden. They requested the use of a plot of land, bought the seeds (very inexpensive) with the health fund money, cleared the land and began planting gourd, pumpkin, bitter gourd, and gilki. The harvest was then distributed among CBO members and some pregnant/lactating non-CBO members. Recently their operations have expanded to a larger plot of land. Also, through this example, a number of families have begun kitchen gardens on small plots of land around their homes.

Plugging gaps in supplies

In the month of July 1999, when government supply of tetanus toxoid were exhausted (or simply unavailable for whatever reason), the women in village Kotla Khedi decided that they were not going to miss their shots. They took money out of their health fund and send a boy to the nearby town to purchase the injections. They then requested that the ANM (Auxilary Nurse Midwife) to come administer the shots to pregnant women.

Drug bank

In two villages, where CBO leadership is strong and communal support equally strong, the CBO has begun a drug bank. This drug bank is run and managed by the group. Commonly used generic drugs such as paracetamol (an over the counter analgesic and antipyretic drug) are bought at the pharmacy and then sold to people in the village at a small profit margin (25 paise). The money then goes back into the fund to service loans and replenish drug supplies.

Looking ahead

Future prospects for the community health fund members are numerous. Several groups have expressed and interest in registering with one or the other government income generation schemes, since the principal requirement of such schemes is that a group be organized and functioning at the village level.

Perhaps a significant outcome of the community health fund has been the several unforeseen community initiatives that it has led to. Again, the outcome of the *aspirations* of a small, cohesive group of motivated individuals -- reminiscent of Margaret Mead's famous quote "never doubt that a small group of thoughtful committed citizens can change the world; indeed it's the only thing that ever does".

CONCLUSION

An important lesson learned is that village women when adequately and appropriately stimulated are capable of evolving rules to manage the health funds. It has shown that community based organizations can effectively generate, manage and utilize health funds for improving access to health care. The process results in village women

being more empowered to take decisions and act so as to work towards their improved well being. Village communities by demonstrating their capacity to effectively manage health funds have shown us that they can carve the path to their well being.

Health Fund and the community based organization help in increasing people's access to information and enable them to make informed decisions and act on them. Health funds have been have proved to be useful in addressing obstetric complications, infant illnesses and have served as an effective gender equity tool. They have also led communities to take on additional initiatives (such as drug bank and plugging gaps in government supplies), that improve health care.

The scope for improvement and/or expansion remains in the hands of community members who, will continue to grow and to innovate new ways to improve their health and the quality of their lives. Given the economic viability of community health financing schemes and the latent empowerment they represent, alternative community-based approaches to health financing are not only relevant but crucial to achieving universal health care and should be considered in discussions of health financing in the developing world.

As Amartya Sen (winner of the 1998 Nobel Prize for Economics) states in his discussion of 'Social Resource Development' as a pre-requisite to social development, development really is the process of expansion of individual freedom, which, in turn, is a function of people's capabilities and opportunities. Community health financing is an example of such expanded individual freedom, whereby, dependence on external agents is lessened, capabilities and opportunities are advanced, and social development takes place.

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